NAVIGATION GUIDE TO MEDICARE SUPPLEMENTAL INSURANCE

A Quick Reference Guide for
SHIP Counseling

The Navigation Guide for Medicare Supplemental Insurance is designed for use during telephone or face-to-face counseling.

All information is presented in the second-person format, using **you** in place of she/he, the person, the beneficiary, etc.

For more detailed information or if you have questions, please contact the SHIP Training Officer at:

1-800-452-4800, 224

MEDICARE SUPPLEMENT INSURANCE

(MEDIGAP POLICIES)

SECTION G

MEDICARE SUPPLEMENT INSURANCE

Introduction

A Medicare Supplement Insurance policy, also known as a Medigap policy, is health insurance sold by private insurance companies to fill the “gaps” in Original Medicare coverage. These gaps in coverage include deductibles, co-insurance, and co-payments. When you purchase a Medigap policy you will pay a monthly premium in addition to your Medicare Part B premium. Medigap policies can be either a group policy or an individual policy. Medigap policies must follow federal and state laws. These laws are for your protection. The front of a Medigap policy must clearly identify it as “Medicare Supplement Insurance.”

Group Policies

Group Medigap policies can be offered by an employer as part of a retirement package, or obtained through an organization that offers this type of insurance to its members (i.e. The American Legion). The employer or organization is the group policyholder. As the group policyholder the employer or organization will determine how and when the policy will pay. Benefits covered by these group policies will vary based on how the policy is structured.

Not all retirement plans are Medigap policies. Many insurance policies offered by employers, labor organizations, or trustees of a fund established by an employer or labor organization are not Medicare Supplement Policies.

Individual Policies

Individual Medigap policies are available for purchase from private insurance companies. Originally these policies covered a variety of benefits. Medigap policies changed with the Omnibus Budget Reconciliation Act (OBRA) of 1990. Beginning January 1, 1992, insurance companies can only sell you a “standardized” Medigap policy. These policies must all have specific benefits so that you can easily compare.

Currently there are 12 standardized Medigap policies available (Medigap Plans A through L). See pages G7-G11 for more information on specific benefits for each plan.

Medigap Policy Requirements

As a Medicare beneficiary you have protections based on federal and state laws. Insurance companies must meet certain requirements in offering Medigap policies. These requirements include:

- **Outline of Coverage**: Insurance agents must give each applicant an outline of coverage, summarizing the policy's benefits and features.

- **30 Day Free Look**: Once you receive the certificate or policy you have 30 days to review the policy and return it for a full refund of premiums paid. This is called a "free look period." If the certificate or policy is mailed to you, the 30 day free look begins the date of the postmark on the envelope.

- **Pre-existing Condition**: While the insurance company can't make you wait for all your coverage to start, it may be able to make you wait for coverage for a pre-existing condition. A pre-existing condition is a health problem you have received treatment before the date a new insurance policy begins.
    - If you have a health problem before your Medigap policy starts, the insurance company can refuse to cover that health problem for **up to 6 months**. This is called a **pre-existing condition waiting period**.

    - The insurance company can only use this waiting period **if your health problem was diagnosed or treated during the 6 months before the Medigap policy starts.**

    - If you buy a Medigap policy during your Medigap Open Enrollment and you had at least 6 months of health coverage that qualifies as "creditable coverage," the company cannot apply a pre-existing waiting period.

- If you had less than 6 months of creditable coverage, this waiting period will be reduced by the number of months you had creditable coverage. For example, if you had 4 months of creditable coverage, the waiting period would be reduced to 2 months.

- Creditable coverage for Medigap policies is defined as any other health coverage you had prior to applying for a Medigap policy, without a break in coverage longer than 63 days. These types of health coverage may be considered creditable coverage:
    - A group health plan (i.e. employer or union plan)
    - A health insurance policy
    - Medicare Part A or Part B
    - Medicaid
    - A medical program of the Indian Health Service or tribal organization
    - ICHIA (state health benefits risk pool)
    - TRICARE (military retirees and dependents)
    - A Federal Employees Health Benefit plan
    - A public health plan
    - COBRA
    - SCHIP (State Children's Health Insurance Program)
  - The following are **not considered** creditable coverage:
    - Hospital indemnity insurance
    - Specified disease insurance (i.e. cancer insurance)
    - Vision or dental plans
    - Long-term care policies

- If you buy a Medigap policy when you have special Medigap protections (also called guaranteed issue rights), the insurance company cannot use a pre-existing condition waiting period.

- If you are replacing a Medigap policy, the new company will waive any waiting periods that apply if you were covered under the old policy.

- **Guaranteed Renewable**: If you purchased your Medigap policy after 1990, the Medigap policy is required to be guaranteed renewable. **This means the insurance company can only drop you if you stop paying your premium, you aren't truthful about something under the policy, or the company goes bankrupt.**

- **Coordination of Benefits**: Medigap policies may not contain benefits that duplicate benefits provided by Medicare. This means the policies will not duplicate any payments Medicare has made. It also means policies will not usually cover services that Medicare would not approve. Exception - some policies will pay for additional benefits not covered by Medicare (such as foreign travel, preventive care, and Part B excess charges).

- **Canceling A Group Master Policy**: When a group policyholder cancels their Medigap group master policy, the insurance company must offer each insured beneficiary the opportunity to convert their group coverage to an individual Medigap policy.

- **Medigap Standardization**: There are **12 standardized plans** that can be sold in any state. These plans were developed by the National Association of Insurance Commissioners (NAIC). They are labeled **Plans A though L**.
    - Each standardized plan will be **identical in benefits** from company to company; however, premiums for each plan may vary from company to company.

    - A state may limit the number of plans sold in that state to less than 12, but **Plan A must be included as one of the plans for sale**.

    - In Indiana, all Medigap insurance companies must offer Plan A, but can choose to sale any of the other 11 plans. Other than Plan A, the insurance companies, in Indiana, are not required to sale any other plan.

    - Not all standardized plans are offered in every state.

- Some states are exempted from federal standardization due to programs in place prior to the law being enacted (Minnesota, Massachusetts, and Wisconsin).

- Some states allow additional benefits to be offered by the insurance company.

- The only US areas where standardization is not in effect are Guam, American Samoa, and the Northern Mariana Islands.

- **Pre-standardized Policies**: If you have a Medigap policy purchased before 1992, then it is most likely a pre-standardized policy.
  - **In Indiana, the standardization law does not effect the pre-standardized policies**. Medicare beneficiaries were not required to purchase a standardized policy.

  - While these policies can no longer be sold, as long as the policies are in effect the benefits will still be covered.

  - Basic benefits for pre-standardized policies included co-payment coverage for Parts A and B, the first 3 pints of blood, and coverage for an additional 365 days of hospitalization (paid at 90%).

  - Insurance companies added various other benefits to these policies and combined then in a number of ways. Many of these policies offered excellent prescription drug coverage.

  - These policies must be reviewed in order to determine what benefits are covered by the policy.

- **Duplication of Coverage**: It is illegal for an agent to knowingly sell you a second Medigap policy, if you already have a Medigap policy, or are in a Medicare Advantage Plan. When you buy a Medigap policy to replace a current policy, you must state in writing that you intend to cancel the first policy after the new policy becomes effective.

- **You should never cancel a Medigap policy until the new one is in your hands and you have decided to keep it.** Just because you want to switch plans does not mean the insurance company has to sell you the plan. If you are not in your Medigap Open Enrollment Period or have a Guaranteed Issue, it is up to the company to choose whether or not to sell you a plan.

- **Medicaid and Medigap**: There are some special situations when it comes to Medicaid and Medigap policies.
    - If you have a Medigap policy and then become a Medicaid member, you can suspend your Medigap policy within 90 days of receiving Medicaid coverage. This suspension can be for up to two years. During this time you will not be required to pay your premiums, but your policy will not pay for benefits. At the end of the suspension, you can restart your policy without new medical underwriting or pre-existing condition waiting periods. As of January 1, 2006, if you suspend your policy and it included drug coverage, you can still get your policy back but without the drug coverage benefit.

    - If you already have Medicaid, an insurance company can sell you a Medigap policy only if:

        - Medicaid pays your Medigap policy premium, or
        - Medicaid pays your Part B premium as part of the Medicare Savings Program.

- **Medicare SELECT**: Medicare SELECT policies are standardized Medigap policies in which there is a payment agreement between the insurance company and specific hospitals. **As a Medicare SELECT policyholder, you agree to use designated providers and in turn you may pay lower premiums.** You may **choose at anytime to switch** to a traditional standardized Medigap policy sold by the company, or a policy containing lower benefit levels. Should the Medicare SELECT program be discontinued, continuation of coverage will be offered to you in the form of a traditional Medigap policy.

Medigap Coverage

Basic Benefits

Each standardized Medigap policy must cover basic benefits. Plans A though J have one set of standardized benefits, and Plans K and L have another set. Most policies pay some if not all of the Medicare coinsurance and co-payments. In addition, Medigap policies can offer "Extra Benefits." These benefits can cover such things as Part A and/or Part B Deductibles, Skilled Nursing co-payments, Foreign Travel, Preventive Care, and the Part B Excess Charge. The following charts list the basic benefits and how they are covered by each Medigap Plan.

Basic Benefits	What Medigap Plans A through J will pay in 2008
Medicare Part A co-payment and hospital benefits	**Medigap Plans A through J pay**: $275 per day for days 61-90 of a hospital stay $550 per day for days 91-150 of a hospital stay (while using your 60 lifetime reserve days) Up to 365 more days for hospital stays during your lifetime after you use all of your Medicare hospital benefits.
Medicare Part B co-payments or coinsurance	**Medigap Plans A through J pay:** all coinsurance and co-payment amounts after you meet your $155 annual deductible for Medicare Part B.
Blood	**Medigap Plans A through J pay:** for the first three pints of blood per year.

Basic Benefits	What Medigap Plans K and L will pay in 2008
Medicare Part A co-payment and hospital benefits	**Medigap Plans K and L pay**: $275 per day for days 61-90 of a hospital stay $550 per day for days 91-150 of a hospital stay (while using your 60 lifetime reserve days) Up to 365 more days for hospital stays during your lifetime after you use all of your Medicare hospital benefits
Medicare Part B co-payments or coinsurance	**Medigap Plan K pays** 50% of the Medicare Part B coinsurance and co-payment amounts after you meet your $155 annual deductible. It pays 100% of the coinsurance for preventive services. **Medigap Plan L pays** 75% of the Medicare Part B coinsurance and co-payment amounts after you meet your $135 annual deductible. It pays 100% of the coinsurance for preventive services
Blood	**Medigap Plan K pays** 50% of the first three pints of blood per year. **Medigap Plan L pays** 75% of the first three pints of blood per year.
Hospice Care	**Medigap Plan K pays** 50% of the cost-sharing for all Part A expenses and respite care. **Medigap Plan L pays** 75% of the cost-sharing for all Part A expenses and respite care.

Overview of Medigap Plans A through L

A	B	C	D	E	F*	G	H	I	J*	K	L
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits (Includes Hospice Coinsur-ance)	Basic Benefits (Includes Hospice Coinsur-ance)
		Skilled Nursing Facility	Skilled Nursing Facility	Skilled Nursing Facility	Skilled Nursing Facility	Skilled Nursing Facility	Skilled Nursing Facility	Skilled Nursing Facility	Skilled Nursing Facility	Skilled Nursing Facility (50%)	Skilled Nursing Facility (75%)
	Part A Deductible	Part A Deductible	Part A Deducti-ble	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible (50%)	Part A Deductible (75%)
		Part B Deductible			Part B Deductible				Part B Deductible		
					Part B Excess Charge (100%)	Part B Excess Charge (80%)		Part B Excess Charge (100%)	Part B Excess Charge (100%)		
		Foreign Travel	Foreign Travel	Foreign Travel	Foreign Travel	Foreign Travel	Foreign Travel	Foreign Travel	Foreign Travel		
			At Home Recovery			At Home Recovery		At Home Recovery	At Home Recovery		
				Preven-tive Care					Preven-tive Care		

* denotes that plans F and J offer high deductible options. The plans pay the same benefits as Plans F and J after you have paid an annual deductible ($1,790).

Extra Benefits

Skilled Nursing Facility Care Co-payment
The amount you must pay for days 21-100 in a skilled nursing facility. In Plans C through J will pay 100% of the co-payment; Plan K pays at 50%, and Plan L pays at 75%.

Part A Deductible
The amount you are responsible for before Medicare will begin to pay for an inpatient hospital stay in each benefit period. Plans B through J will pay 100% of the deductible; Plan K pays at 50% and Plan L pays at 75%.

Part B Deductible
The initial amount that you must pay each year before Medicare will begin to pay Part B services. Plans C, F and J will pay 100% of the deductible.

Part B Excess Charge
The difference between Medicare's approved payment amount and the doctor's or health care provider's actual charge subject to any limiting charge. Plans F, I and J pay 100% of the excess charge; Plan G pays 80% of the excess charge.

Foreign Travel Emergency
Generally, Medicare pays nothing for health care outside of the United States. Plans C through J will pay 80% of health expenses for emergency care after you pay a $250 deductible. This care must be received within the first 60 days of each trip. There is a $50,000 lifetime maximum.

At-Home Recovery
If you have Plans D, G, I or J and you receive Medicare-covered home health benefits, the Medigap policy may pay up to $40 per visit for additional, non-Medicare covered visits to assist you with Activities of Daily Living (ADLs) during recovery from an illness, injury, or surgery. Certain limits apply such as:

- Total number of at-home recovery visits cannot exceed the total number of Medicare covered visits.
- After the date of the last home visit covered by Medicare, the policy will only pay for benefits for up to 8 additional weeks.
- The policy pays maximum of $1,600 per year.

- The visits are limited to 4 hours in duration, $40 per visit, and 7 visits per week.

Preventive Care
If you have Plan E or J you may pay nothing for routine yearly checkups and any non-Medicare covered preventive services your doctor recommends. This benefit has a $120 per year limit.

Note: Plans H through J purchased prior to January 1, 2006, included prescription drug benefits. Plan J offered a Drug Benefit-you pay an annual deductible, and the Medigap plan pay 50% of your prescription drug costs up to a maximum of $3,000 per year.

Plans H and I offered a Basic Drug Benefit - You pay an annual $250 deductible, and the Medigap plan pays 50% of your prescription drug costs up to a maximum of $1,250 per year.

Plan J offered a Drug Benefit - You Pay an annual deductible, and the Medigap plan pays 50% of your prescription drug costs up to a maximum of $3,000 per year

After January 1, 2006, Medigap policies could no longer be sold with the drug benefits as they did not provide coverage as good as the Medicare Prescription Drug Plans (PDP). Beneficiaries who had plans that offered drug coverage could choose to do one of the following:

- Keep their Medigap policy and its drug coverage,
- Purchase a Medicare PDP and drop their Medigap policy's drug benefit, or
- If they purchased a Medicare PDP before May 15, 2006, they had a guaranteed issue to switched to another Medigap policy.
- If they waited until after May 15, 2006, to purchase a Medicare PDP, they will likely pay a higher premium for their PDP and lose their right to switch to another Medigap policy.

You can drop the Medigap policy's drug coverage only if you purchase a Medicare PDP. If you have drug coverage that is considered creditable coverage for a PDP (such as VA, retirement benefits, etc), you cannot drop your Medigap policy's drug benefit. Creditable coverage is not the same as a Medicare PDP.

Medigap Open Enrollment

The best time to buy a Medigap policy is during your Medigap open enrollment period. **Your open enrollment period lasts for 6 months. It starts on the first day of the month in which you are both age 65 or older, *and* enrolled in Medicare Part B.** Once your open enrollment period starts, it cannot be changed.

During this time, the insurance company:

- **cannot deny you any Medigap policy it sells**
- **make you wait for all your coverage to start**
- **charge you more than the standard rate for any Medigap policy because of your health problems** (medically underwrite your policy).

While the insurance company cannot make you wait for all your coverage to start, it may be able to make you wait for coverage of any pre-existing conditions - this is called a pre-existing condition waiting period. **This waiting period cannot not be longer then 6 months.** Prior health insurance coverage (creditable coverage) reduces or eliminates this waiting period. The insurance company can only use this waiting period **if your health problem was diagnosed or treated during the 6 months before the Medigap policy starts.**

If you buy a Medigap policy during your Medigap open enrollment and you had at least 6 months of health coverage that qualifies as “creditable coverage” the company cannot apply a pre-existing waiting period. If you had less than 6 months of creditable coverage, this waiting period will be reduced by the number of months you had creditable coverage. For example, if you had 4 months of creditable coverage, the waiting period would be reduced to 2 months. (Note: a list of types of creditable coverage is included on page G-3).

Whether you had creditable coverage depends on whether you had any **“breaks in coverage” - when you were without any type of health coverage for more than 63 days in a row**. If you have had one or more breaks in coverage, but each break was shorter than 63 days, then you can add the periods of coverage together.

You can send in your application for a Medigap policy before your open enrollment period begins. This may be important if you currently have coverage that will end when you turn 65. This will allow you to have continuous coverage, without any break.

Federal law allows individuals **under 65 and on Medicare due to disability** to receive a Medigap open enrollment period once they turn 65 years old.

If you are **over 65** and have delayed enrolling in Medicare Part B for any reason, you will have a Medigap open enrollment period once you enroll in Medicare Part B and coverage goes into effect.

If you are unsure if your Medicare open enrollment has passed and you are 65 or older, check your Medicare card. Look at the effective date for your Part B coverage and add 6 months. If that date is in the future you are in your open enrollment. If that date is in the past your open enrollment is over.

If your open enrollment period is over, the insurance company is allowed to use medical underwriting to decide whether to accept your application and how much to charge you for the policy. There is no guarantee that the company will sell you a policy, unless you fall under a “Guarantee Issue Protection.” Under guarantee issue, if you meet certain conditions you may have the right to purchase a Medigap policy without underwriting, and the company cannot deny your application.

Medigap Policy Pricing

Each insurance company sets its own premiums. It is important that you ask how the insurance company sets the prices for their Medigap policies. The method used will effect how much you will pay now and in the future. Medigap policies can be priced in three ways:

1. Community-rated (or no-age-rated)
2. Issue-age-rated
3. Attained-age-rated

Type of Pricing	How it's Priced	What Pricing May Mean for You	Examples
Community-rated (also called no-age-rated)	The same monthly premium is charged to every-one who has the Medigap policy, regardless of age.	Premiums are the same no matter how old you are. Inflation will affect the premium.	Mr. Smith is age 65. He buys a Medigap policy and pays a $165 monthly premium. Mrs. Perez is age 72. She buys the same Medigap policy as Mr. Smith. She also pays a $165 monthly premium because with this type of policy, everyone pays the same price regardless of age.
Issue-age-rated	The premium is based on the age you are when you buy (are issued) the Medigap policy.	Premiums are lower for younger buyers. Inflation will affect the premium.	Mr. Han is 65. He buys a Medigap policy and pays a $145 monthly premium. Mrs. Wright is age 72. She buys the same Medigap policy as Mr. Han. Since she is older at the time she buys it, her monthly premium is $175.
Attained-age-rated	The premium is based on your current age (the age you have "attained") so your premium goes up each year.	Premiums are low for younger buyers, but go up every year and can eventually become the most expensive. Inflation will affect the premium.	Mrs. Anderson is age 65. She pays a $165 monthly premium. Her premium will go up every year. • At age 66, her premium goes up to $171 • At age 67, her premium goes up to $177 • At age 72, her premium goes up to $189

Medigap Plans and Disability or ESRD

In Indiana, insurance companies can choose to sell Medigap Plans A, B, C or F to individuals under 65 and have Medicare due to disability or ESRD (End Stage Renal Disease). **You must be allowed to purchase Medigap Plans A, B, C or F, if the company chooses to sell to those Medicare beneficiaries under 65.** The monthly premium for these plans may cost you more than policies sold to those over the age 65.

If you are already enrolled in Part B, when you turn 65 years old you will have a 6 month Medigap open enrollment period. This open enrollment period will begin the first day of the month you turn 65 years of age. It does not matter that you have had Part B before you turned 65. During this time:

- you can **purchase any Medigap policy** from any company;
- insurance **companies cannot refuse to sell** you a Medigap policy due to disability or other health problems;
- insurance **companies cannot charge you a higher premium** based on health status than they charge other people who are 65 years old.

When you buy a Medigap policy during your open enrollment period, the insurance company must shorten the waiting period for any pre-existing conditions by the amount of creditable coverage you have. If you had Medicare Part A and/or B for more than 6 months before you turned 65 years old, and you didn't have a break in coverage of 63 or more days, you will not have a pre-existing waiting period.

If you are under 65, have a Medigap policy and have employer group health coverage, you have the right to put your Medigap on hold (suspend your coverage). If you want to suspend your Medigap coverage, you will need to contact your insurance company. Your Medigap coverage will stop, and you will not have to pay your monthly premium while you are enrolled in your or your spouse’s employer group health plan.

When you want to reinstate your Medigap policy, you will not have to pay more for your monthly premium than you would otherwise have to pay if you had not suspended your policy.

Medicare Rights and Protections

In some situations you have the right to buy a Medigap policy outside of your open enrollment period. These rights are called “Medicare protections.” They are also known as “guaranteed issue rights” because the law stated that insurance companies must sell (or issue) you a Medigap policy even if you have health problems. These rights are for both Medigap and Medicare SELECT policies. During this time the insurance company. . .

- must sell you a Medigap policy,
- must cover all your pre-existing conditions, and
- can’t charge you more for your policy because of past or present health problems.

In some situations you have a guaranteed issue right to buy a Medigap policy if you lose certain types of health coverage. You should keep a copy of any letters, notices and claim denials that show you have lost your coverage. Keep anything that has your name on it and any postmarked envelopes to prove when it was received by mail.

It is best to apply for a Medigap policy before your current health coverage ends. This will prevent any breaks in coverage. There may be times when more than one situation applies to you. If that is the case, you may choose the Medigap company that gives you the best choice for policies.

Situations in which you may qualify for a "Guarantee Issue."

There are 7 situations in which you may qualify for a guarantee issue right. These situation include:

Situation #1: You are in a Medicare Health Plan rather than the Original Medicare Plan and the plan is going to leave the Medicare Program or stop giving care in your area.

Your Medicare Health Plan will send you a letter letting you know when your coverage will end. This letter will also include information on any other Medicare Health Plans in your area. You have the option to switch to one of the Medicare Health Plans in your area (in this case you will not need a Medigap policy) or switch to Original Medicare and purchase a Medigap policy.

If you decide to switch to Original Medicare:

- You have the right to buy a **Medigap Plan A, B, C, F**, **K**, **or L**.
- You may leave you Medicare Health Plan any time after the day you receive your letter, but before your coverage ends.
- You may choose to remain in your Medicare Health Plan until your coverage ends.
- You will have **63 days from the day your coverage ends** to apply for a Medigap policy.

Situation #2: You have an employer group health plan or union coverage that is ending.

In this situation, you are in the Original Medicare Plan and you also have coverage from an employer group health plan or union, including COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage.

- If you lose coverage for one of the following reasons:
  - The employer goes out of business
  - The employer stops offering the health plan
  - Your are no longer eligible for the health plan (i.e. if your coverage is from your spouse and you divorce, or your spouse dies)
  - You have COBRA coverage that is ending

- You have the right to buy a Medigap Plan **A, B, C, F, K, or L**.

- You must apply or the policy within 63 days after the latest of these dates:
  - The date your coverage ends,
  - The date on your notice that coverage is ending, or
  - The date on your claim denial, if this is the only way you know that your coverage has ended.

- If the employer offers you COBRA coverage you can either buy a Medigap policy right away or you can wait until the COBRA coverage ends then you will have another right to buy a Medigap policy.

Situation #3: Your coverage ends because you move out of the plan's service area.

If you receive your health coverage from a Medicare Advantage Plan or are in PACE (Program of All-inclusive Care for the Elderly), and you move out of the plan's service area, you will have to end your coverage.

- If you have a Medicare SELECT policy, you can keep your policy because it is guaranteed renewable. However, because you have moved, you may not be able to use a hospital or other providers that are not in the policy's network. If this is the case you may want to consider switching to another Medigap Plan.
- You have the right to buy **Medigap Plans A, B, C, F**, **K**, **or L.**
- You must tell your current pan that you are moving and give them a date when your coverage will end.
- You may apply for a Medigap policy **as early as 60 days before your coverage ends**.
- You must apply for a Medigap policy **no later than 63 days after** your coverage ends.

Situation #4: You joined a Medicare Advantage Plan or PACE when you were first eligible for Medicare at age 65 and within the first year of joining, you decide you want to switch to the Original Medicare Plan.

Medicare Advantage Plans are managed care plans. These plans can be HMO (health maintenance organization), PPO (preferred provider organization) or PFFS (private-fee-for-service) plans. In this situation. . .

- You have the right to purchase **any Medigap Plan** A through L.
- You must tell the health plan that you want to leave (disenroll) and give them date to end your coverage.
- This date must be **before you have been in the plan for a year (twelve months)**.
- You can apply for a policy as **early as 60 days before your coverage ends**.
- You must apply for a Medigap policy **no later than 63 days after** your coverage ends

Situation #5: You dropped a Medigap policy to join a Medicare Advantage Plan or other Medicare Health Plan (or to switch to a Medicare SELECT policy) for the first time; you have been in the plan less than a year; and you want to switch back.

If the same insurance company still sells it, you have the right to go back to the Medigap policy you had.

- You must tell the health plan that you want to leave (disenroll) and give them the date to end your coverage.
- This date must be **before you have been in the plan for a year (twelve months)**.
- If your former Medigap policy is not available, you have the right to buy a Medigap Plan **A, B, C, F, K, or L**.
- If your former policy included prescription drug coverage, you have the right to go back to the plan if the same insurance company still sells it, but you will not be able to get the drug coverage back.
- If your former policy included drug coverage, even if the same company still sells the plan, you have the right to purchase a Medigap Plan A, B, C, F, K or L. You will have to purchase a separate drug plan for your prescription coverage.
- You can apply for a policy as **early as 60 days before your coverage ends**.
- You must apply for a Medigap policy **no later than 63 days after** your coverage ends

Situation #6: Your Medigap insurance company goes bankrupt and you lose your coverage, or your Medigap policy coverage otherwise ends through no fault of your own.

Because Medigap policies are guaranteed renewable, the only way you would lose coverage under a Medigap policy would be if the company goes bankrupt or the coverage ends through no fault of your own.

- You have the right to purchase **a Medigap Plan A, B, C, F**, **K**, **or L.**
- You must apply for a Medigap policy **no later than 63 days after** your coverage ends.

Situation #7: You leave a Medicare Advantage Plan or drop a Medigap policy, because the company hasn't followed the rules or it misled you.

In this situation you leave the Medicare Advantage Plan because it failed to meet its contract obligation to you. For example, the company isn't paying your claims, or it made untrue statements to convince you to buy the policy.

- You have the right to purchase **a Medigap Plan A, B, C, F**, **K**, **or L.**
- Generally to have this right you must have filed a grievance with the Medicare Advantage Plan, Medicare, or the Indiana Department of Insurance and received a decision that the Medicare Advantage plan was at fault.
- You must tell the Advantage Plan that you want to leave (disenroll) and give them a date to end coverage.
- You must apply for a Medigap policy **no later than 63 days after** your coverage ends.

Laws for Insurance Companies and Agents

Advertising

- An advertisement which contains information concerning Medigap cannot refer to Medicare on the envelope, the reply envelope, or the address side of the reply postcard.
- Also prohibited is any language to imply that failure to respond would jeopardize Medicare benefits.
- The company's complete address and name must appear on all documents and advertisements.
- Advertisements must prominently disclose that they are advertisements for insurance or that they are intended to obtain insurance prospects.

An agent must:

- Identify themselves as insurance agents (with name, address and telephone number) and identify the company for which they work.

- Give the consumer a receipt for materials (documents, cash, checks, etc.) given to them by the customer.

- Completely disclose the purchaser's medical history on the application (when medical history is required).

- Give the purchaser an Outline of Coverage at the time of application. This is an overview of what the policy covers.

- If an existing Medigap policy is to be replaced, give the applicant a Notice Regarding Replacement of Medicare Supplement Insurance.

- Not use any false, deceptive, or misleading representation to induce a sale; nor use any methods of marketing having an effect of or tending to induce the purchase of insurance through force, fright or threat; whether explicit or implicit.

Please report any violations by agents to:
Indiana Department of Insurance's Consumer Services
1-800-622-4461

Illegal Insurance Practices

It is illegal for any company or individual to:

- Pressure you into buying a Medigap policy, lie, or mislead you to get you to switch from one company to another.
- Sell you a second Medigap policy.
- Sell you a Medigap policy, if they know you have Medicaid, unless they understand that exceptions can be made if Medicaid pays your Medigap premiums, or Medicaid pays only your Part B premium.
- Sell you a Medigap policy if they know you are enrolled in a Medicare Advantage Plan.
- Claim that a Medigap policy is part of the Medicare program or any federal program.
- Sell you a Medigap policy that cannot be sold in Indiana.
- Misuse the names, letters, symbols or emblems of the U.S. Department of Health and Human Services (DHHS), Social Security Administration (SSA), Centers for Medicare and Medicaid Services (CMS) or any other programs like Medicare.

Discrimination

It is illegal to discriminate (treat a person differently from everyone else) based on Race, Color, Sex, Disability, Age or National Origin. Report violations to the department of Health and Human Services, Civil Rights Division.

Financial Stability

Several private rating agencies conduct financial analyses of insurance companies. Their ratings on the financial health of those companies analyzed are published along with useful information about each company. Different rating scales are used by each rating service, and the rating scales may change without notice. To get a clear picture of a company's status, check what each service uses as a top rating. The published ratings may be found in the reference section of local public libraries or by contacting the rating agencies as listed below

Remember there may be a charge to your telephone bill for "900" number calls. Some of these agencies may also charge you for verbal and/or written financial reports. Be sure to ask about charges at the beginning of your call.

A.M. Best Company

Three options to access this service:

1. Website: www.ambest.com Ratings are free after you register.
2. Call 1-908-439-2200 You may charge materials to your phone bill.
3. Call 1-808-424-BEST to use your VISA or MasterCard.

Duff & Phelps (Fitch Investors Service, Inc.)

For a free rating of a single company call 1-800-853-4824, ext 199

Fitch Investors Service, Inc.

Up to 5 verbal rating, no charge 1-800-892-4824, ext 199

Moody's Investor Service

1-212-553-0377 No charge for up to three ratings
www.moodys.com

Standard & Poor's Services

1-212-438-2400 No charge for up to ten ratings
www.standardpoor.com Ten free ratings on email

Weiss Research, Inc.

1-800-289-9222 Charge for rating reports, ask for fee schedule.